Lewisham Clinical Commissioning Group

NHS Lewisham Clinical Commissioning Group

Risk Management Strategy

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Further Guidance	NHSLA Risk Standards for PCTs

Table of Contents

1. Introduction

1.1. Background

This strategy has been revised in response to structural changes to be implemented as a result of the Health and Social Care Act (2012).

Our aims and ambitions to secure health improvement, reduce health inequalities and enhance service quality, require significant transformation in the way that health services are commissioned and delivered. With transformational change comes uncertainty and the enhanced need to mitigate the associated risks. Risk management is therefore central to the effective running of NHS Lewisham Clinical Commissioning Group (LCCG) and the delivery of our objectives.

The Risk Management Strategy for LCCG describes the key principles, processes, procedures and responsibilities in place within the LCCG in order to ensure best practice risk management is consistent across the organisation. The LCCG is committed to the application and embedding of these best practice principles across all services and actively communicating these principles with NHS stakeholders in an effort to share best practice risk management activities.

LCCG operates two major systems to facilitate the management of risk throughout the organisation. These are through implementation of the Serious Incident Policy and the Board Assurance Framework along with development and maintenance of directorate and corporate risk registers. Risk management processes are the primary means by which effective financial, clinical and non clinical governance will be achieved and are the responsibility of all staff.

1.2. Policy Statement

Risk Management Strategic Statement

The Governing Body is committed to leading the organisation to deliver effective, high quality healthcare which meets the needs of local people and makes the very best possible use of public funds. The Governing Body intends to use the risk management processes outlined in this Strategy as a means to help achieve these goals. NHS Lewisham Clinical Commissioning Group will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks and in line with our duties as a responsible public sector organisation and with the CCG Constitution.

1.2.1. In addition to the above, LCCG has agreed to utilise a Risk Appetite Matrix (Appendix 4) to assess the CCG's risk appetite and compliments other risk management tools. This will be further developed through organisational development actions.

1.3. Aim and Objectives

The overall aim of the Risk Management Strategy is to create a risk management framework, appropriate processes and a culture which encourages appropriate risk taking, effective performance management and organisational learning in order to continuously improve the quality of the services provided.

The organisation is aiming to create an environment in which risk is considered as a matter of course, appropriately identified and controlled by elimination, or reduction to an acceptable level at an acceptable cost. At its simplest, risk management is good practice and should not be seen as an end in itself, but as part of an overall management approach.

The objectives to achieve these aims include:

- Ensuring all corporate, strategic, clinical and financial risks which may adversely affect LCCG's operational ability are identified and managed through a robust Board Assurance Framework and accompanying Corporate and Directorate risk registers.

- Integrating established local risk reporting procedures alongside quality and governance issues to ensure an effective integrated management process throughout all LCCG's activities.

- Managing clinical and non-clinical risks facing the LCCG in a co-ordinated manner to enable LCCG to provide high quality support to clinical commissioning leads.

- Ensuring that the Lewisham Clinical Commissioning Group's Governing Body is kept suitably informed of significant risks facing the organisation and associated mitigation plans, in order that it is able to effectively govern the organisation.

- To reflect the aims and objectives of the CCG Constitution

2. Scope of document

This strategy is intended for use by all directly employed, and agency staff and contractors, including South London Commissioning Support Service (SLCSS), engaged on Lewisham work in respect of any aspect of that work. Although the key strategic risks are identified and monitored by LCCG Governing Body, operational risks are managed on a day-to-day basis by staff throughout LCCG. In order that progress in managing all risks can be acknowledged, Directorates maintain local Risk Registers and escalate Significant Risks to the Board Assurance Framework.

3. Definitions

(Adapted from the Australian/New Zealand standard AS/NZS 4360:1999.)

3.1 Risk

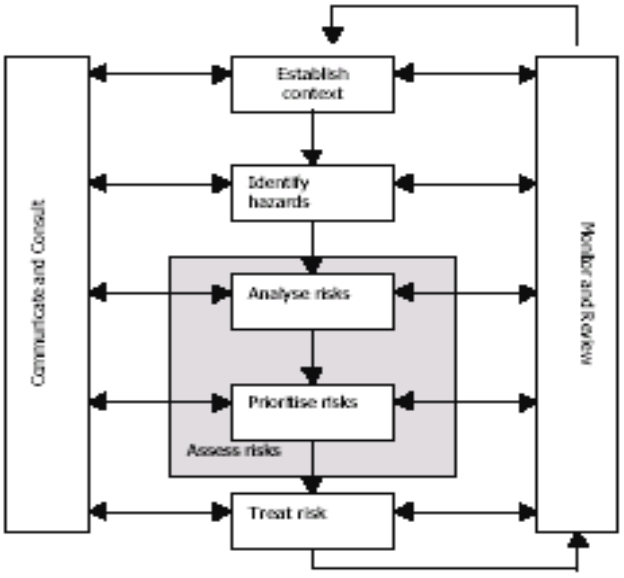
Risk is the chance that something will happen that will have an impact on achievement of the organisations aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring). See Appendix 3

3.2 Risk Management

Risk Management is “the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects”.

The risk management process is “the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process in the way that will enable organisations to minimise losses and maximise opportunities”. It is described in the following diagram:

Australian Standard AS/NZS: 4360/1999



The adopted risk management process is designed to provide continuous identification, assessment, control, communication and monitoring of risk via defined timescales, reporting and escalation processes and supporting tools and techniques.

3.3 Significant Risks

Significant Risks are those which, when measured according to LCCG’s risk grading tool at Appendix 2, are assessed to be ’Extreme’. The Governing Body will take an active interest in the management of significant risks

3.4 Acceptable Risks

These are risks which have been identified and measured according to the risk grading tool and for which risk mitigation action plans have been developed. Such risks are deemed to be acceptable according to the risk appetite of LCCG, a delegated committee or Directorate, depending on the nature and grade of the risk. Acceptable risks should be monitored, reviewed and entered onto the appropriate risk register. By this definition an unacceptable risk is one where such a risk is rated above the risk appetite of LCCG.

3.5 Risk Appetite

Risks need to be considered in terms of both opportunities and threats, and this approach, not usually confined to money, involves taking considered risks where the long-term benefits outweigh any short-term losses. These decisions will invariably also impact on the capability of an organisation, its performance and reputation.

The Risk Appetite is the aggregated account of the board's willingness (to allow management) to take risks in the pursuit of strategic objectives. It is the level, amount or degree of risk that the LCCG or a particular delegated authority is willing to accept and is a guide for staff on the limits of risk that they can take.

Risk Appetite is measured through the Risk Maturity Matrix (Appendix 4). There are five risk levels identified in the matrix:

- Avoid (no appetite) = avoidance of risk and uncertainty is a key organisational objective
- Minimalist (low appetite) = preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
- Cautious (moderate appetite) = preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
- Open (high appetite) = willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.)
- Seek (significant appetite) = eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

4. Organisational Accountabilities and Responsibilities

4.1 LCCG Governing Body

The LCCG Governing Body is responsible for setting the strategic direction of the organisation in consultation with members and stakeholders and to have an oversight of the risk management arrangements across the organisation. The Governing Body delegates the day-to-day management of risk, such as risks to the delivery of QIPP, to the Risk Management Group which is chaired by the Accountable Officer (AO). The Risk Management Group will give regular reports on corporate risk to the Delivery Committee.

The LCCG Governing Body is required to manage all aspects of its risk through a clearly defined management and committee / sub-group structure. The Membership of the Governing Body includes GP-clinical lead representation for Governance and Risk Management, in addition to a lay member lead for Risk Management.

The Governing Body relies on the Delivery Committee to provide regular briefings on risk, quality and governance matters and escalate matters of significant concern in relation to risk management and organisational and clinical governance. The Delivery Committee is chaired by LCCC Chair or Vice Chair.

4.2 Risk Management Group

This group is responsible for the day-to-day management of risk and for implementing strategic direction for risk within the organisation, on behalf of the LCCG.

Operational implications of strategic decisions for all areas of the organisation are discussed, and action is agreed at the monthly meetings of the Risk Management Group. Much of the discussion involves weighing up risks and benefits of certain courses of action.

Risk comprises elements of financial, clinical and non-clinical activity, including financial, strategic, operational and hazard related activities. It is therefore necessary to provide an arena in which these issues can be discussed and developed by their appropriate lead whilst eliminating either too much overlap or the potential for omission. The Risk Management Group will undertake:

- To co-ordinate and oversee the development of a Risk Management Strategy across LCCG
- To put into place systems, policies and procedures that help the LCCG effectively prioritise and manage risk management issues, including key risks to the delivery of QIPP
- To ensure compliance with relevant regulatory, legal and code of conduct requirements as set out in relevant guidance
- To ensure that the appropriate funding required to respond to risk management issues is identified and report to the Governing Body

4.3 Delivery Committee

The Delivery Committee will oversee the performance of commissioned health services in all aspects and to monitor delivery of the CCG's Operational Plans and is responsible for receiving and monitoring the Assurance Framework, corporate risk register, action plans arising from internal and external inspection and is also responsible for those risks arising from incidents, including Serious Incidents (SI's), claims or complaints. In overseeing the delivery of the Operational Plan and QIPP, the committee will receive progress and risk updates on Operational Plan initiatives, clinical redesign programmes and QIPP initiatives, and decide any change to objectives, scope, approach, timescale or staffing which members deem necessary to meet commitments.

They will provide both routine and annual reports to the Audit Committee and LSL Integrated Performance Committee on risk management arrangements and activities.

4.4 LCCG Audit Committee

The LCCG Audit Committee is responsible for providing assurance to the Governing Body that an effective system of internal control for all risks is maintained within the organisation. The Committee is chaired by a lay member and meets at least 4 times a year. The Committee may review the results of audit work completed on LCCG's risk management system and performance. The Committee will also agree an annual audit plan with reference to LCCG Board Assurance Framework. The Audit Committee also has a specific remit around reviewing and providing verification on the systems in place for risk management as part of its assurance for the Annual Governance Statement.

4.5 Other Committees / Sub-Groups

Clinical risks will be escalated to the Delivery Committee through its subgroups such as FLAG (For Action and Learning Group), Prescribing and Medicine Management Group and Health Safeguarding Group.

5. Individual Accountabilities and Responsibilities

5.1. Accountable Officer

The Accountable Officer for LCCG is responsible for signing the Annual Governance Statement on behalf of the Governing Body. This Statement is a comment on how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal system of control has been reviewed and supports achievement of the organisational objectives. This document is a requirement of the Department of Health (DH). The Accountable Officer has overall Executive responsibility for risk management. This responsibility is delegated to the LCCG for its implementation.

5.2 All Employees

The management of risks is a fundamental duty of all staff whatever their grade, role or status. All staff must follow LCCG policies and procedures that explain how this duty is to be undertaken. In particular:

- Staff must ensure that identified risks and incidents are dealt with swiftly and effectively by reporting to their immediate line manager in order that further action may be taken where necessary. All incidents / accidents and near misses should be reported using the CCG Incident Reporting System (Datix) per the Incident Policy and the Corporate Director informed.

- Be aware that all staff have a statutory duty to take reasonable care for their own safety and that of others who may be affected by their actions or inactions.

- All employees should neither intentionally, nor recklessly interfere with or misuse or fail to use when required, any equipment provided for the protection of safety and health as pursuant of the Health & Safety at Work Act (1974).

- All staff should be aware of emergency procedures e.g. evacuation and fire precaution procedures etc relating to their particular Service / Department locations.

- Ensure that relevant risk management training is completed e.g. Health and Safety, fire, Information Governance, Safeguarding, Equality and Diversity.

5.3 Managers

All managers within LCCG are accountable for the day-to-day management of risks of all types within their area of responsibility. They are charged with:

- Ensuring that risk assessments are undertaken throughout their area of responsibility on a pro-active basis, that preventive action is carried out where necessary and action plans and risk registers (Directorate and Organisation) are regularly updated.

- Monitoring performance, health and safety standards including risk assessments, safe systems of work, use of personal protective equipment etc. ensuring that these are reviewed and updated regularly and the level of compliance meetings agreed internal controls.

- Ensure that all staff have the necessary information and training to enable them to work safely and to comply with LCCG's internal control systems.

- Seeking advice about implementation of risk reduction plans from their Director, lead Director for financial, non financial or clinical risk or lead Director for Governance as appropriate.

5.4 Member Practices

Member Practices are bound by statutory obligations in the same way as the LCCG (Health and Safety at Work Act 1974, Environment Act, COSHH Regulations etc). In addition all clinicians are responsible to their professional bodies for their clinical practice. As such they need to ensure that they are managing clinical and non-clinical risks appropriately.

Member practices need to comply with their regulatory bodies and respective standards of professional practice. For GPs this includes complying with incident investigation and reporting systems of their employing or contracting body. (GMC standards: Good Medical Practice)

The role of LCCG is to support member practices in the management of risk as part of their day-to-day activities.

5.5 Chief Financial Officer (Finance Director)

The Finance Director has delegated responsibility for all aspects of financial and information risk related to the LCCG's financial arrangements and statutory obligations.

5.6 Corporate Director

The Corporate Director is responsible for advising on and co-ordinating risk management activities within LCCG and is responsible for ensuring that appropriate reports are created from the Risk Register, events and risk management training databases and that these are presented to at the relevant Group or Committee. The **Medical Director/Nurse Director** is responsible for advising on clinical governance risks.

The Corporate Director is responsible for developing and creating a risk aware culture

reflected in all aspects of clinical and non clinical practice and supporting Directors, staff and Clinical Commissioning Leads in their identification and management of risk as part of good Governance.

5.7 All Directors

Directors are responsible for providing risk management leadership and sponsorship across the LCCG. Each Director is responsible for the management of risk in their own area of responsibility, ensuring that risks are identified, Directorate and Board Assurance Framework (BAF) is updated and action plans are appropriate to the level of risk. The Directorate Risk Register and BAF for escalated (significant) risks.and action plans should be updated and monitored monthly.

5.8 Risk Management Specialists

There are a number of risk management specialists within the CCG including:

- Director of Finance- Financial Risk Lead and SIRO (Senior Information Responsible Officer) for LCCG
- Safeguarding Designated Leads for Children and Young People; and for Vulnerable Adults
- Health Safeguarding Group: Executive body responsible for providing child and adult protection leadership across Lewisham's health system and reports to London Borough of Lewisham's Strategic Boards.
- Caldicott Guardian – Medical/Nurse Director
- Corporate Director - Lead for all aspects of clinical & non-clinical governance; aspects of risk management and quality; SI reporting and incident management; and Board Development on risk management
- Emergency Planning Manager: Lead for all aspects of Business Continuity Planning and Emergency Response & Resilience. Acts in an Advisory capacity to LCCG.
- Information Governance Manager (SLCSS): Lead for all Information Governance related activities for LCCG
- Health & Safety Advisor(s): Lead for all health & safety related matters including incident reporting and analysis, inspections and related audit

5.9 Stakeholder Partnerships

LCCG recognises that specific risks identified by LCCG will be shared with other relevant organisations working in partnership. This strategy recognises the potential inherent risks of shared service arrangements.

6. Risk Management Process

LCCG has adopted the Australian/New Zealand standard (AS/NZS 4360:1999) risk management standard. This standard is internationally recognised, providing a generic

model for the identification, analysis, prioritisation, treatment, communication and monitoring of risks across clinical and non clinical services and activities at local and corporate level. There are 7 stages to manage risk in this model:

1. Establish the context
2. Identify hazards
3. Analyse risks
4. Prioritise risks
5. Treat risks
6. Monitor and review
7. Communicate and consult

Each stage of the process should be documented.

An overview of the process was included under section 3.2 The process is designed to provide continuous identification, assessment, control, communication and monitoring of risk via defined timescales, reporting and escalation processes and supporting tools and techniques.

6.1 Risk Prioritisation

When considering risk, it is vital to have a qualitative method of defining risk that enables risk prioritisation and appropriate action.

6.2 Risk Grading

Prioritisation can be achieved by applying the risk grading matrix below. The same grading tool is used by LCCG for all risk processes (risk assessment, risk register, complaints and incident reporting assessment) and is consistent with guidelines provided by the National Patient Safety Agency (NPSA).

Grade	Definition	Risk Score
Red	Extreme Risk	15-25
Amber	High Risk	8-12
Yellow	Moderate Risk	4-6
Green	Low Risk	1-3

Risks which attract the highest scores are therefore graded ‘red’ and warrant immediate attention by relevant personnel. These risks are significant and may threaten the achievement of LCCG’s objectives. They should be reported to the Corporate Director.

Appendix 1 provides a schematic overview of the CCG risk reporting and escalation process.

6.3 Risk Scoring

A risk score is achieved by the multiplication of an individual severity (impact) score with an individual likelihood (probability) score:

Risk = Impact x Likelihood

The CCG risk scoring matrices are consistent with the NPSA guidelines (January 2008) and are aligned to the Trust adopted AS/NZS 4360:19999 risk management standard.

Risk matrices for calculating an overall risk score can be found in Appendix 2.

A specific risk matrix for Personal Data related incidents is included in Appendix 3 .

6.4 How to manage risk

Risk information is structured and includes details on the description, causes, controls, score and agreed action plans for all risks presented to the Risk Management Group. The monitoring of such risks can therefore be undertaken and the effectiveness of risk performance and measured over time.

Risks to the CCG can be:

- **Accepted**: low risks can be accepted as requiring no further action. On reviewing this type of risk it may, however, be decided that some cost effective action would reduce the risk still further. Action on this risk is a lower priority.

- **Mitigated:** Managing risks through the application of controls within the intention of driving down the risk to an acceptable level. This is where the likelihood and consequence of a risk occurring are reduced or controlled through actions. There are two ways to mitigating a risk by introducing:

- Containment actions; to lessen the likelihood or consequence and applied before the risk materialises or;

- Contingent actions**;** put into place after the risk has happened in order to reduce the impact.

- **Transferred**: LCCG is a member of the Liabilities to Third Parties and Property Expenses risk pooling schemes run by the NHSLA. This membership transfers some financial risk to these risk pooling schemes. Additionally, a risk that is the responsibility of another organisation, such as SLCSS, may be 'transferred' for management with their acknowledgement although accountability will continue to be held by the CCG.

- **Managed**: in many cases action can be taken to reduce the risk identified. NHS Lewisham is committed to using a systematic / holistic approach to risk management.

- **Avoided**: in some cases risk cannot be accepted, transferred or managed. The Board may then decide a particular risk should be avoided altogether which may involve ceasing the activity giving rise to the risk.

Where risk treatment plans require significant additional funding, or changes to the working pattern of LCCG, these decisions will be made by the Governing Body. Decisions with less significant implications will be taken by the Finance Director. There is no central risk management budget. All departmental budgets should include a sum for risk management activities.

Definition	Further Action	By whom
Extreme Risk 15-25	Significant Risk. The root causes should be identified to help determine the most appropriate risk action plan. ▪ Report to Governing Body identifying treatment options ▪ Monthly Board Integrated Governance and Performance Report ▪ Quarterly quality provider reports to LSL Integrated Performance Committee ▪ The Risk Management Group will monitor progress on action plans	Corporate Director
High Risk 8-12	Unacceptable Risk. ▪ Report to the Delivery Committee identifying treatment options followed by monthly highlight and exception reports ▪ Monthly report to Risk Management Group monitoring progress on treatment action plans	Directors/Senior Managers
Moderate Risk 4-6	Acceptable / Unacceptable Risk To be assessed and actioned accordingly as for 'High' risk or 'Low risk'.	Directors
Low Risk 1-3	Acceptable Risk ▪ Informal all appropriate stakeholders ▪ Take action to reduce risk where necessary and within authority ▪ Maintain records ▪ Discuss whether any further action should be taken to reduce further risk	Senior Managers

6.5 Board Assurance Framework (BAF)

In 2002/3 national guidance required all NHS Bodies to set up an Assurance Framework to include active involvement of nominated Boards and Audit Committees. The 2007 Audit Handbook identifies that the Audit Committee should review the strategic processes for risk, control and governance of the organisation. The Assurance Framework is a key tool for the identification and control of risks.

The Board Assurance Framework is designed to provide the Audit Committee with assurance that the organisation is effectively managing, or has plans in place designed to manage, risks that may threaten the achievement of the organisation's annual objectives.

The BAF forms part of the annual operating plan review and incorporates new or revised corporate objectives.

The BAF consists of the following elements:

- Identify the principal objectives of the organisation
- Define the principal risks which threaten the achievement of each objective
- Identify the key controls applied to manage the risks
- Gain assurances (including independent assurances from Audit) about the effectiveness of the key controls
- Identify any assurance gaps and make arrangements to verify the effectiveness of the key controls
- Report separately and discretely to the Governing Body and the Audit Committee during the year.

6.6 Risk Registers

LCCG has both a top-down and bottom-up approach to risk management from the BAF, to corporate risk register and directorate risk registers.

The LCCG will set the strategic direction for risk management across the organisation, with reporting and mitigation activities undertaken in line with this direction. Risks of 12 or greater are reported to the Audit Committee and to the Governing Body through the BAF with exception reports being produced for risks rated 15 and over.

The LCCG in adopting a Risk Appetite and Risk Tolerance approach to corporate objectives for 2012/13 may require other risks to be reported. This process will develop during the year.

Directorate Risk Registers: Each directorate will revise its risk register on a monthly basis using the corporate risk register template and discuss and monitor risks and action plans at directorate meetings.

Risks graded 15-25 'red' will be escalated to the Corporate Risk Register for review by the LCCG. The LCCG Corporate Director will work with Directors and delegated responsible parties to assess the quality of risk register entries including descriptions, causal factors, scoring and action plans. The Risk Management Group will discuss new and developing risks.

Corporate Risk Register: The Corporate Risk Register provides an organisation-wide snapshot of significant risks. Actions will be updated monthly by identified risk leads and new risks added following agreement with the Risk Management Group. The risk register will be reviewed monthly by the Corporate Director preceding reports.

6.7 Managing Risk across Organisational Boundaries

It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks is most difficult to ascertain. LCCG will endeavour to involve partner organisations in all aspects of risk management as appropriate

7. Annual Governance Statement

NHS Lewisham Clinical Commissioning Group should be aware of and manage, through local risk management and governance arrangements in place, the risks to which the constituent organisations, individual staff members and the wider public are exposed. To meet the requirements of the Annual Governance Statement the Governing Body is required to have in place:

- Clear objectives which provide the framework for all organisation activity
- Structured risk identification systems covering all risks
- Robust control in place for the management of risk
- Appropriate monitoring and review mechanisms, which provide information (and assurance) to the Board that the system of risk management across the organisation is effective.

Risk management links together clinical care (clinical governance), the environment of care (organisational controls) and financial resources (financial controls) and ensures that a continuous process of risk management improvement is undertaken.

The NHS Lewisham Clinical Commissioning Governing Body from 1 April 2013 will publish, as part of its Annual Report, an Annual Governance Statement which will identify those significant risks that threaten the attainment of its underlying objectives. The publication of serious incidents is also required, as per guidance

8. Risk Management Training

Risk Management training is currently available in the training brochure in the form of ‘statutory and mandatory training’. This includes fire, manual handling, health and safety awareness, information governance, equality and diversity and child protection.

9. Related Strategies

The following NHS Lewisham CCG Policies and Procedures are relevant to this policy:

- Health & Safety Policy
- Incident Policy
- Complaints Policy
- Whistleblowing Policy
- Disciplinary Policy and Procedure
- Grievance and Disputes Procedures
- Clinical Policies
- Counter Fraud and Corruption Policy
- Information Governance Policies

10. NHS Lewisham CCG Stakeholders

Key stakeholders include:

- Staff (directly employed and agency)
- Practice members
- SLCSS
- NCB London Region
- Private sector providers of NHS care when covered by NHS Lewisham
- Public and service users

11. Communications

Systems of communication with stakeholders that contribute to minimising risk are in place. These systems include LCCG website, publications, the annual general meeting and Board meetings.

Communication with staff is particularly important and is mainly effected via line management at team meetings. Any urgent or particularly important messages are communicated by email, and the monthly staff briefing. Health and Safety Group representatives feed back and support staff locally in relation to specific relevant issues. A staff survey is carried out annually.

The Risk Management Strategy is available to all staff via LCCG intranet and to other stakeholders on NHS Lewisham website. The introduction of new or significantly revised risk management policies is support by appropriate staff training.

12. Audit and monitoring criteria

Document Audit and Monitoring Table	
Monitoring requirements - what in this document do we have to monitor	a) Directorate risk registers b) Corporate Risk Register c) Risks over 12 (BAF)
Monitoring Method: (*e.g. statistics, report***)**	a) Register and written report b) Written report and register c) BAF, heat map and exception reports for risks over 15
Monitoring prepared by :- (name job titles)	a) Directors b) Corporate Director c) Corporate Director
Monitoring presented to:- (e.g. Committees)	a) Risk Management Group b) Delivery Committee c) Audit Committee and Governing Body
Frequency of presentation:- (e.g. annually, six-monthly etc)	a) Monthly b) Monthly c) Audit Committee – Quarterly; Governing Body - monthly

13. Implementation and dissemination of document

On approval this updated policy and guidance will be published on the NHS Lewisham CCG internet and intranet and staff advised through the communications bulletin and NHS Lewisham email of its publication.

14. Appendices

Appendix 1 LCCG Risk Management Process

Appendix 2 Risk Scoring Tool

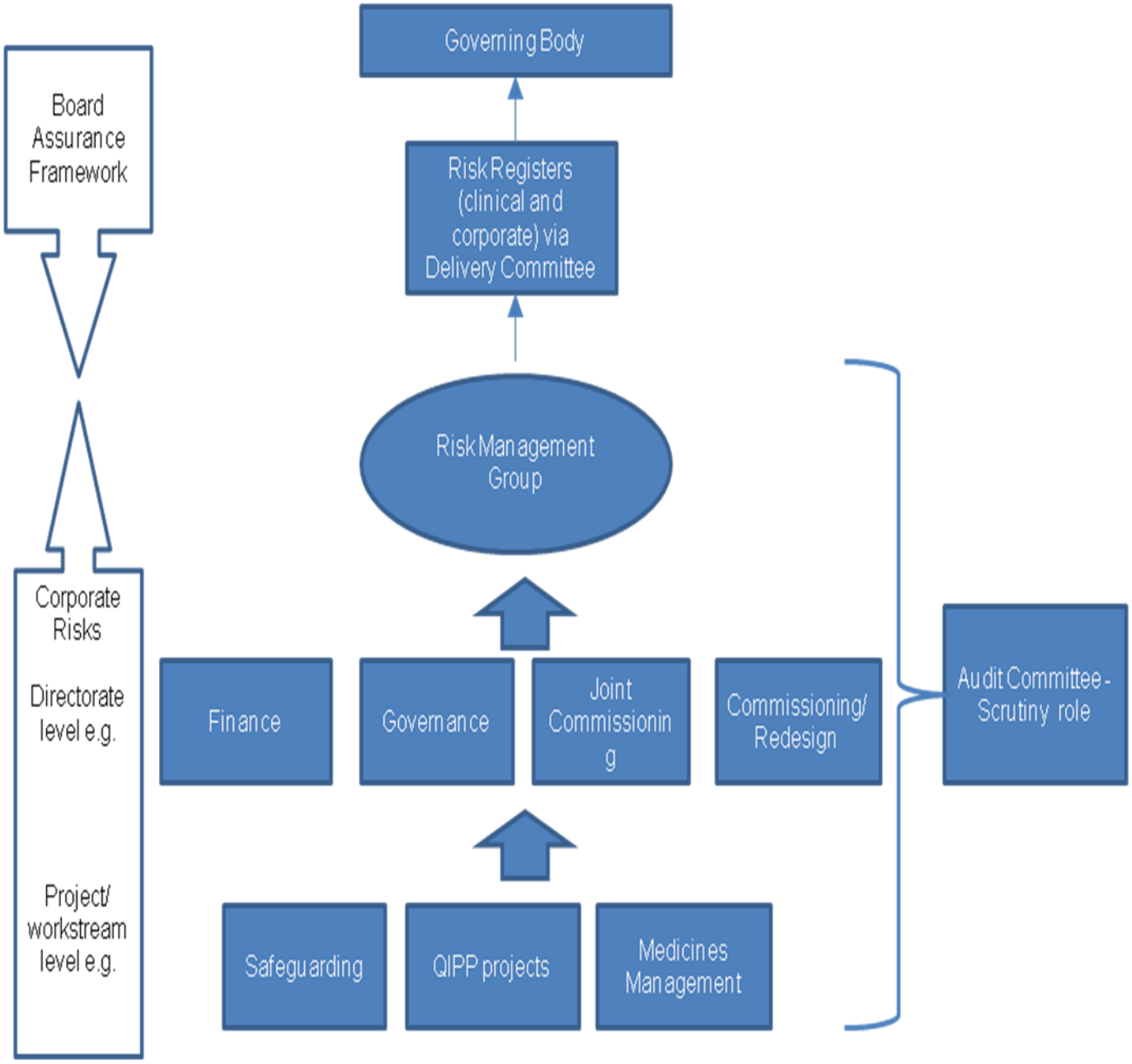
Appendix 3 Impact (Consequence) Table

Appendix 4 Risk Appetite for NHS Organisations

Appendix5 Equality Impact Assessment Checklist

Appendix 6 Consultation History

NHS Lewisham Clinical Commissioning Group Risk Management Process



Appendix 2 Risk Scoring Tool

The matrix below represents the possible combined scores based on a measurement of both the impact (severity) and likelihood (probability) of risk issues. The combination provides the risk score.

Risk = Likelihood x Impact (Consequence)

Risk Scoring Matrix

Risk Matrix	Impact				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

The risk score can be used to prioritise mitigation actions based on an understanding of the nature of the risk presented as presented below.

Step 1 – Likelihood Risks are first judged on the **likelihood** of the risk being realised. The following categories are available for grading

Score	Descriptor	Description
1	Rare	Cannot predict that an event of this type will occur in the foreseeable future. The event **may** occur only in exceptional circumstances.
2	Unlikely	The event **could** occur at sometime
3	Possible	The event should occur at sometime
4	Highly likely	The event **will** occur in most circumstances.
5	Certain	The event is **expected** to occur in most circumstances.

Step 2 – Impact (Consequence)

Situations are then judged to evaluate, if the risks were to be realised, what the outcome is most likely to be. The following categories are available for grading.

Score	Descriptor	Description
1	Negligible	First aid treatment. Moderate financial loss.

2	Minor	Medical treatment required. Moderate environmental implications. High financial loss. Moderate loss of reputation. Serious business interruption.
3	Moderate	Serious injuries. Serious environmental implications. Serious financial loss. Serious loss of reputation. Serious business interruption.
4	Major	Excessive injuries. High environmental implications. Major financial loss. Major loss of reputation. Major business interruption.
5	Catastrophic	Single or multiple deaths of any persons.

See Appendix 3 for detailed Impact (Severity) table.

Step 3 - Plot the likelihood and severity on the following matrix.

Based on the above judgements, a risk assessment can be made of the potential future risk to stakeholders and the organisation as follows.

Risk Matrix	Impact				
Likelihood	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

Risk	Low	1-3	Moderate	4-6	High	8-12	Extreme	15-25

Step 4 – Risk Decisions

Risks to NHS Lewisham CCG can be:

- **Accepted**: low risks can be accepted as requiring no further action. On reviewing this type of risk it may, however, be decided that some cost effective action would reduce the risk still further. Action on this risk is a lower priority.

- **Mitigated:** Managing risks through the application of controls within the intention of driving down the risk to an acceptable level. This is where the likelihood and consequence of a risk occurring are reduced or controlled through actions. There are two ways to mitigating a risk by introducing:

- Containment actions; to lessen the likelihood or consequence and applied before the risk materialises or;

- Contingent actions**;** put into place after the risk has happened in order to reduce the impact.

- **Transferred**: LCCG is a member of the Liabilities to Third Parties and Property Expenses risk pooling schemes run by the NHSLA. This membership transfers some financial risk to these risk pooling schemes. Additionally, a risk that is the responsibility of another part of the organisation e.g. SLCSS may be 'transferred' for management.

- **Managed**: in many cases action can be taken to reduce the risk identified. NHS Lewisham is committed to using a systematic / holistic approach to risk management.

- **Avoided**: in some cases risk cannot be accepted, transferred or managed. The Board may then decide a particular risk should be avoided altogether which may involve ceasing the activity giving rise to the risk.

Appendix 3: Impact (Consequence) Table

Impact Categories	Negligible	Minor	Moderate	Major	Catastrophic
Injury / Harm (physical /psychological)	Minimal injury requiring no/ minimal intervention or treatment. No time off work	Minor injury or illness, first aid treatment / minor intervention required Requiring time off work for <=3 days Increase in length of hospital stay by 1-3 days	Significant injury requiring professional intervention (medical treatment and/or counselling) Requiring time off work for 4-14 days Increase in length of hospital stay by 4 – 15 days RIDDOR reportable (absence more than 7 days) An event which impacts on a small number of patients	Major injury leading to long term incapacity or disability (e.g. loss of limb) Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met	Local media coverage – moderate loss of public confidence in the organisation	National media coverage with <3 days service well below reasonable public expectation. Long term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in House). Total loss of public confidence in the organisation.
Business objectives /	Insignificant cost increase / schedule slippage	<5% over project budget Schedule slippage or minor	5-10% over project budget Schedule slippage or	Non-compliance with national 10-25% over	Incident leading >25% over project budget

Impact Categories	Negligible	Minor	Moderate	Major	Catastrophic
projects	Barely noticeable reduction in scope or quality	reduction in quality / scope	reduction in quality / scope	project budget Schedule slippage Key objective not met	Schedule slippage Key objectives not met
Service Business Interruption	Loss interruption of 1-8 hours Minimal or no impact on the environment /ability to continue to provide service	Loss interruption of 8-24 hours Minor impact on environment / ability to continue to provide service	Loss of interruption 1-7 days Moderate impact on the environment / some disruption in service provision	Loss interruption of >1 week (not permanent) Major impact on environment / sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of service or facility Catastrophic impact on environment / disruption to service / facility leading to significant “knock on effect”
Personal Identifiable Data (serious incident)*	Damage to an individual’s reputation. Possible media interest e.g. celebrity involved Potentially serious breach Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team’s reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Damage to a service reputation. Low key local media coverage. Serious breach of confidentiality e.g. up to 100 people affected.	Damage to an organisations reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected.
Complaints / Claims	Locally resolved complaint Risk of claim remote	Justified complaint peripheral to clinical care e.g. civil action with or without defence. Claim less than £10k	Below excess claim. Justified complaint involving lack of appropriate care. Claim(s) between £10k and £100k	Claim above excess level. Claim(s) between £100k and £1 million. Multiple justified complaints	Multiple claims or single major claim >£1 million. Significant financial loss >£1 million

Impact Categories	Negligible	Minor	Moderate	Major	Catastrophic
HR/Organisational Development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces service quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training. .	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objectives / service due to lack of staff Ongoing unsafe staffing levels or incompetence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Financial (damage/loss/ fraud	Negligible organisational/financial loss (£< 1k)	Negligible organisational/financial loss (£1000- £10000)	Organisational/financial loss (£10000 -100000)	O/financial loss (£100000 - £1m)	Organisational/financial loss (£>1million)
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards Reduced performance rating if unresolved	Reduced rating Challenging recommendations Non-compliance with core standards Prohibition notice served.	Enforcement action Low rating Critical report. Major non-compliance with core standards. Improvement notice	Prosecution. Zero rating. Severely critical report. Complete systems change required.

Good Governance Institutev2.2 Nov 2011	Appendix 4 Risk Appetite for NHS Organisations - A maturity matrix to support better use of risk in decision taking					Developed with Southwark BSU
Risk levels ® **Key elements ©**	**0 Avoid** **Avoidance of risk and uncertainty is a Key Organisational objective**	**1 Minimal (ALARP)** **(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential**	**2 Cautious** **Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.**	**3 Open** **Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)**	**4 Seek** **Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).**	**5 Mature** **Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust**
Financial /VFM	Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself
Compliance / regulatory	Avoid anything which could be challenged, even unsuccessfully. Play safe	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
Innovation/ Quality / Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	**SIGNIFICANT**	

Appendix 5 - Equality & Equity Impact Assessment Checklist

This is a checklist to ensure relevant equality and equity aspects of proposals, policy or guidance have been addressed either in the main body of the document or in a separate equality & equity impact assessment (EEIA)/ equality analysis. It is not a substitute for EEIA/ equality analysis which is normally required unless it can be shown that a proposal has no capacity to influence equality. The checklist is to enable the policy lead and the relevant committee to see whether the EEIA has covered the ground and to give assurance that the proposals will not only be legal but also fair and equitable and lead to reduced health inequality.

	Challenge questions	Yes/No/DK/NA	Comments
1.	Does the document set out the **health care needs** of the groups intended to benefit from the proposal, including any differences in need in terms of the legally protected or other characteristics such as those defined under the Equality Act (2010)*	NA	
2.	Does the document set out any known existing inequality in **access**, **quality**, **experience** and **outcome of care** for populations relevant to the proposal (ie as defined in 1. and in relation to the existing health or care service)?	No	Though the need to consider risks relating to issues of equity are mentioned
3.	Are there any particular **public concerns** about equality about the policy area than need to be addressed?	No	
4.	Has the policy described any **gaps in knowledge** about 1 -3, and any action taken to fill gaps (or recommendations for action)	Yes	It is highlighted that risks which require mitigation should have an action plan and that this would be monitored.
5.	Does the document set out **risks to equity** of access, quality, experience and outcomes **including risk of direct or indirect discrimination**, and risk to **good relations** between people of different groups?	Yes	When identifying risks staff are reminded to consider risks relating to issues of equity.
6.	Does the document describe any specific **opportunities to promote equality and human rights**, good relations between people of different groups, to enhance participation, etc?	Yes	When identifying risks staff are reminded to consider risks relating to issues of equity.
7.	Does the document describe how the proposal, policy etc will **address** the **identified inequalities,** and	Yes	The policy states that risks which require mitigation should have an action plan and that this would be monitored.
8.	Does the document make recommendations to **mitigate risks** and **enhance the opportunities to promote** equality and equity?	No	
9.	Does the document describe how **monitoring and reporting** will take place to assure equality and equity in the future including to stakeholders. [audit and monitoring table may be used]	Yes	The policy covers how risks should be monitored and reported within the organisation and the responsibilities of all staff in this process
	*Protected characteristics under equality legislation are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation		

Appendix 6 - Consultation History

Stakeholders **Name**	**Area of expertise**	**Date sent**	**Date received**	**Comments**	**Changes made**
Martin Wilkinson	Managing Director	9 July 2012	10 July 2012	Changes throughout document	Incorporated
Senior Management Team	Senior Managers	11 July 2012		Changes made	Incorporated
GP Executives	Clinical	12 July 2012		No comments made	
LCCC meeting	Board level	26 July 2012	20 July 2012	Approved	